Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

VETERAN'S REFERRAL
(PART 1)

DSHS OFFICE	TELEPHONE	CASE NUMBER	CASE NAME

A. Check the items that apply to you or the person you are applying for

1. ☐ **Veteran**

2. ☐ **Widow or Widower** of a veteran who died while on active duty or as a result of a service-connected disability. Widow or widower has not remarried, or if remarried the marriage was annulled or was terminated by legal action started before 11-1-90.

3. ☐ **Widow or Widower** of a wartime veteran who died of non-service related conditions. Widow or widower has not remarried, or if remarried the marriage was annulled or was terminated by legal action started before 11-1-90.

4. ☐ **Parent** of a veteran who died while on active duty or as a result of a service-connected disability.

5. ☐ **Child**, who is under age 26, of a veteran who died or who is permanently and totally disabled as the result of a service-connected disability.

6. ☐ **Child** of a veteran who died while on active duty or as a result of a service-connected disability. Child was totally and permanently disabled before his/her 18th birthday.

7. ☐ **Child** of a deceased wartime veteran. Child was totally and permanently disabled before his/her 18th birthday.

8. ☐ **Child** of a deceased wartime veteran. Child is under age 23, single, and attends school full time.

B. If you checked any item in Section A above, check all items below that apply to you or the person you are applying for.

1. ☐ Has disabilities related to the service.

2. ☐ Is permanently and totally disabled because of disabilities not related to the service, and served during a wartime period.

3. ☐ Needs medical care.

4. ☐ Needs nursing home care.

5. ☐ Is applying for in-home care under the COPES program.

6. ☐ Needs in-home care under the _____ program (specify).

C. Complete this section if you checked item(s) in BOTH Sections A and B above.

1. NAME OF VETERAN (LAST, FIRST, MIDDLE)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA CLAIM NUMBER (IF KNOWN)

D. Read the following carefully. Sign, date and return this form to your DSHS office.
Failure to return this form may result in denial of DSHS benefits.

I declare that the information given above is correct, true and complete to the best of my knowledge. I understand that I may be required to contact a Veterans Service Office as a necessary part of the application process. I hereby authorize DSHS and Veterans Service Office to release information necessary to determine eligibility for benefits.

If I think that DSHS is wrong in asking for this information, I can ask for a fair hearing within 90 days from the date of this referral by writing to: Department of Social and Health Services, Office of Appeals, PO Box 2465, Olympia, Washington 98507-2465.

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE	DATE